

PAPER

Good medical ethics

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Received 15 August 2014
Accepted 21 August 2014

ABSTRACT

This paper summarises the features of my paper, 'Voluntary Active Euthanasia', and a later jointly authored paper, 'Moral Fictions', which I believe are examples of good medical ethics.

I retired from my position as Frances Glessner Lee Professor of Medical Ethics and Director of the Division of Medical Ethics at Harvard Medical School at the end of 2013. I was trained as a philosopher and gradually drifted into medical ethics and a full time position within a medical school over a 45-year academic career. I like to think that I did at least some good contributions to the field of medical ethics during those years, though it is for others to make that judgment. Looking back, as is inevitable at the end of a long career, and focusing on my own work, what made at least some of it successful? Interestingly, the first answer that comes to mind I have already violated in this paper. Let me explain. If you have a reasonably long and reasonably successful career, particularly in a growing field like medical ethics, you receive many invitations to write papers for conferences, journals and volumes of essays. Inevitably, at least in my case, you accept many of these invitations and they can come frequently enough that they end up constituting much of your publications. Is this a good thing, does it promote 'good medical ethics'? My own experience says no. The paper of mine that has been reprinted at least 40 times, probably more than all my other papers combined, in various collections is 'Voluntary Active Euthanasia,' published in the Hastings Center Report in 1992.¹ How did I come to write that paper? Not as a result of any invitation from the journal, a conference organiser or anyone else. The topic, together with the very closely related topic of physician-assisted suicide, had then begun to receive much professional and public attention. Since the Quinlan case went to the New Jersey Supreme Court in the mid-1970s, decisions about life-sustaining treatment (LST) had dominated medical ethics, both for the public and the professions. Those issues had begun to achieve at least some, though far from a complete, consensus and physician-assisted suicide, and euthanasia were in some respects a natural next step in these debates. But while most participants in these debates supported the rights of patients or their surrogates to decide about and to refuse LST, most also opposed physician-assisted suicide and voluntary euthanasia. This meant that they faced the task of morally distinguishing the practices they supported from those they opposed. In the course of doing so it seemed to me that there were many bad

or confused arguments being offered. So as any philosopher worth his or her salt likely would, I set out to write a paper that attacked those bad arguments and exposed those confusions. These issues were already of considerable interest to me and on which I had already written at least a bit, but I emphasise that the motivation to write that paper was entirely internal—my interest in the issues and my assessment of the state of work on them. Unlike the present paper, I had no external motivation in the form of an invitation from an editor or any other urging from anyone to write that paper. While one's past work, even on the same or a related topic, can of course give an editor or conference organiser some evidence of what you might have to say on some topic, their evidence is inevitably fragmentary and incomplete. A potential author, in this case me, should have the best evidence on that question. Of course, even one's own evidence will be incomplete. Indeed, I find one of the most satisfying parts of the process of writing philosophical and bioethical papers to be discovering and developing new issues and arguments that you had not recognised or thought through before you had actually begun the writing process. Nevertheless, I have found that I am the best, though imperfect, judge of how interesting a particular issue is to me and what I might have to say on it. In this case, I already knew I was very interested in the issue and thought that I had quite a lot to say on it. Let me briefly illustrate the latter point, forewarning the reader that I will only point to arguments here; the arguments themselves can be found in the paper.

At the outset I argued that it was important to distinguish ethical assessments of individual cases of voluntary active euthanasia (VAE) and physician assisted suicide (PAS) from assessments of practices of each. This seems obvious, but failures to do so were one source of problems in many arguments and claims. It was common for many to believe that VAE was much more ethically problematic than PAS and, in particular, that the physician's role in VAE in directly and intentionally causing death could not be justified. This might be true in some cases, but in others the physician's role was equally causally necessary in bringing about the death, and I argued this could not be an intrinsic difference between all VAE and PAS making the former more ethically problematic. I went on to argue that the central ethical argument supporting VAE—the patient's self-determination and well-being—was the same as that which was widely accepted as justifying patients' right to decide about LST. This seems difficult to oppose, but opponents of VAE commonly argued that VAE, but not LST,



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To cite: Brock DW. *J Med Ethics* 2015;41:34–36.

was the deliberate killing of an innocent person and that this was always wrong. Here, I pursued what I took to be the very common, but mistaken, appeal to the ethical importance of the distinction between killing and allowing to die. Even if this difference was ethically important, which I did not believe, the more important point that cases like voluntarily removing a respirator dependent patient from the respirator were examples of killing and, not, as so commonly believed, allowing to die. To support this point, I used my example of the greedy son who performs the same action on his mother as her physician was going to do. Of course, there were other important ethical differences between the physician's and the greedy son's actions in my example—consent, motivation and social role—but none of these were intrinsic to the difference between killing and allowing to die. This illustrated another common difficulty I found in many discussions of VAE, and of many other bioethical issues for that matter, of assuming a difference in one case carried over to all cases. No decently trained philosopher would, or certainly should, make this mistake, but many contributors to bioethics do not have serious philosophical training in careful and rigorous argument. Training in careful, rigorous argument, whether from philosophy or elsewhere is necessary for good bioethics and unfortunately too much bioethics displays both its importance and its absence.

I went on to argue that the difference between killing (causing death) and allowing to die (failing to prevent death) was not in itself morally important and gave examples to support my view. Overall, this discussion of individual cases of VAE gave me the opportunity to challenge many common views, assumptions and arguments that had infected many discussions of these issues. I then went on to consider the public policy issue—would it be ethically justified to make PAS or VAE legally permissible? This issue, as do many bioethics policy issues, depends on what the consequences of doing so would be. Claims of this sort should always be backed by evidence that is provided for them. That evidence should be assessed for how conclusive it is for the claims it is offered to support. This should again go without saying, except that for controversial issues like VAE and PAS it is all too common to make empirical claims about the consequences of permitting them while offering little if any evidence for those claims, much less any assessment of the decisiveness of the evidence. I have not investigated this point, but I have a definite impression from reading the literature on these topics over the years that there is a strong correlation between the positions of the authors and the claims they make about the consequences that permitting these practices would produce. Of course, that might just be because the evidence is so strong and clear in one direction, but since the claims about it are so conflicting, they cannot all be so decisive.

A second aspect of assessing the consequences of permitting VAE or PAS requires not just determining what would happen if that is done, but ethically evaluating those consequences; are particular consequences good or bad, and how good or bad, permissible or impermissible and never to be risked and so on. And arguments should be offered for these evaluations. Again, this should go without saying, but it unfortunately does not. And it should certainly not be assumed that we share the same evaluations of the consequences. I recall that it was Daniel Callahan (apologies to Dan if my memory is faulty) who reported hearing the claims, on the one hand, that it would be impermissible if a policy ever denied anyone VAE who wanted it but, on the other hand, that it would be impermissible to institute a policy that would lead to any abuse of VAE. These were of course claims made by different individuals, but they

illustrate how different the ethical assessments of policy consequences can be. Moreover, such absolute claims are rare, if ever plausible, in the context of assessing consequences of real world policies—that is virtually always a matter of balancing positive and negative consequences, together with their likelihood. Good bioethics must deal much more carefully than is often done with empirical and ethical claims made about consequences. An example of misplaced policy assumptions that I cited was the common belief that PAS and VAE were more subject to abuse than other commonly accepted actions, in particular stopping or not starting LST. What count as abuses will be decisions and actions that are in conflict with the patient's wishes, or what the patient would have wanted. But why assume that VAE was more subject to this abuse. At that time, as now, it was commonly accepted that surrogates, typically a family member, could decide to stop or not start an LST for an incompetent patient. VAE, on the other hand, required a contemporaneous decision by a competent patient. I argued that what were most subject to abuse were practices in which someone else decided for the patient as opposed to practices in which the patient decided for him or herself. Indeed, there were even then, a number of studies showing that family members were often mistaken about what their family member patient would want, even when there has been some prior discussion of this among the parties. So, the worries about abuse were misfocused on the wrong cases and practices.

In a later paper entitled 'Moral Fictions', I and coauthors Franklin Miller and Robert Truog took a further step in our discussion of these issues which illustrates something important in good medical ethics more generally.² We imagined cases of two patients critically injured in motorcycle accidents and left quadriplegic. The first, John, is now, 2 years later, on a home ventilator and finds his condition intolerable and wishes to enter the hospital again to have treatment stopped so that he may die peacefully. The second, Sam, has been weaned from the ventilator and, likewise, finding his condition intolerable asks his physician to administer a lethal dose so that he may die peacefully. The first has his wish granted by his physician since it is agreed that he is entitled to stop this LST. The second patient's physician refuses his request because voluntary euthanasia is illegal (in most jurisdictions) and contrary to conventional medical ethics. I and many other commentators have challenged whether there is any justifiable basis for assigning a significant ethical basis to this difference. We show in the paper that common differences between the two cases often thought ethically important, in fact, do not apply. This critique that many have made has been accepted by many medical ethicists and medical professionals, but it has been resisted by many others. We suggested that the concept of 'moral fictions' can help explain this resistance. 'Fictions are false statements; but not all false statements are fictions. Fictions are motivated false statements, endorsed in order to uphold a position felt to be important'.² (By stressing the motivated character of moral fictions, we do not suggest that the motivation to endorse false beliefs is always conscious.) For those critics who do not share the motivation—the commitment to the position in question—fictions appear to be patently false or confused. Moral fictions are false statements endorsed to uphold cherished or entrenched moral positions in the face of conduct that is in tension with these established moral positions. Professionals are uncomfortable with the thought that they may be practicing unethically. Especially when routine practices, viewed candidly, appear to conflict with established norms, there is a strong incentive to construe these practices in a way that removes the conflict.

Moral fictions serve this purpose. In other words, moral fictions can be understood as a tool for counteracting a form of cognitive dissonance²—specifically, the cognitive dissonance constituted by the inconsistency between routine practices and prevailing norms.

Two types of moral fictions are on display in the standard assessment of John's request to withdraw LST (see table 1). First, as we demonstrate below, the description of withdrawing LST involves a series of motivated false factual statements. These include false statements about the nature of the patient's request, the nature of the act that clinicians are asked to perform in this case, the causal relationship between the act of treatment withdrawal and the patient's death, and the intention of physicians who accede to such requests. Second, there are erroneous moral judgments based on these mistaken factual claims: judgments about moral responsibility and moral permissibility. When shorn of these moral fictions, the differential moral assessment of complying with the patient requests of John and Sam is undermined.

In this later paper from which I have extensively quoted above, we employed the concept of moral fictions, illustrated with the cases of John and Sam, to explain how those fictions can be used to support the conventional ethical difference found between John's and Sam's cases. Without those fictions the two cases lose the bases that conventional medical ethics (and the law) appeal to for ethically distinguishing them.

But is the concept of moral fictions only useful in this context of end-of-life practices, in which case it has only limited relevance to good medical ethics more generally? On the contrary, I believe moral fictions can be found in many discussions of the

issues of medical ethics, and so illustrating that can be useful to good medical ethics more generally. There is space here to provide only one example. In transplantation, the widely accepted 'Dead Donor Rule' requires that organs to be used for transplantation only be taken after the death of the donor. I and others have criticised this rule elsewhere, but it remains widely accepted and respected within the practice of transplantation. One consequence of this rule is that organs cannot be taken from patients refusing further LST until those patients are, in fact, dead. But this means that their organs will have deteriorated from their condition before death has occurred. They will be less useful for, and will produce less successful results in, transplantation because of the dead donor rule, although that rule seems to have no benefit for the organ donor. In the face of this situation, some transplantation centres developed the concept of 'irreversible loss of circulatory function'. In these cases, a patient who has decided to die by stopping LST and who wishes to donate his organs for transplantation is taken to the Operating Room, the LST such as a respirator removed and the patient declared dead within 2–5 min and then the organs for transplantation removed. This has the advantage of producing better quality organs for transplantation than waiting for standard criteria for the declaration of death to be met. But is this declaration of death a moral fiction? What has made some commentators believe it is is that an uncontroversial condition of death is irreversibility—once it occurs, it cannot be reversed and the patient cannot live again. But in this practice, death is often declared within 2–5 min after the treatment is removed. If cessation of circulatory function occurred in a patient who wanted to live, resuscitation would be attempted and would sometimes be successful beyond this 2–5 min period. But the notion of irreversibility of death is that death cannot, not will not, be reversed, and this notion of irreversibility seems violated by this practice. This declaration of death used in this practice seems a moral fiction used to avoid violating the dead donor rule.

I leave it to others to examine the medical ethics literature for other examples of moral fictions. But I believe that identifying the notion of moral fictions facilitates identifying other examples of their occurrence in medical ethics. One function, although only one, of good medical ethics can be to identify these occurrences. It is then possible to address whether to attempt to remove that moral fiction. I emphasise that sometimes the conclusion may be that the fiction should be left in place. Sometimes, to take the example just discussed, the conclusion may be to accept the assessment that death has occurred, despite its lack of irreversibility. That might be because the dead donor rule is too deeply entrenched to be changed, or because it has good consequences in other cases, and so all things considered, has good consequences in the practice of transplantation. Nevertheless, one role of good medical ethics can be to identify moral fictions and to assess whether they should be abandoned or retained. Identifying and assessing moral fictions is just one way in which good medical ethics can contribute to ethical clarity in medicine. Needless to say, there are other ways it can do so as well that I have not touched on here.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

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- 2 Miller FG, Truog RD, Brock DW. Moral fictions and medical ethics. *Bioethics* 2010;24:453–60.

Table 1 Consider two cases: (1) ventilator-dependent quadriplegic requests withdrawal of ventilator (WSLT); (2) quadriplegic, who has regained spontaneous breathing and weaning from ventilator, requests lethal dose of medication (VAE)

	WSLT	VAE
Status quo		
Is the doctor causing death?	No	Yes
Is it an active intervention?	No	Yes
Is the doctor intending death?	No	Yes
Does the doctor kill the patient?	No	Yes
Is it suicide?	No	Maybe
Is it assisted suicide?	No	Maybe
Is the doctor morally responsible for death?	No	Yes
Is it permitted morally?	Yes	No
Is it legal?	Yes	No
Without moral fictions		
Is the doctor causing death?	Yes	Yes
Is it an active intervention?	Yes	Yes
Is the doctor intending death?	Sometimes Yes, sometimes No	Yes
Does the doctor kill the patient?	Yes	Yes
Is it suicide?	Yes	Yes
Is it assisted suicide?	Yes	Yes
Is the doctor morally responsible for death?	Yes	Yes
Is it permitted morally?	Yes	Yes
Is/should it be legal?	Yes	Open question

VAE, voluntary active euthanasia; WSLT, withdrawing life-sustaining treatment.